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WHAT WE KNOW AND DON'T KNOW ABOUT THE ROLE OF APOLOGIES IN RESOLVING HEALTH CARE DISPUTES

Jennifer K. Robbennolt*

INTRODUCTION

The role of apologies in resolving all types of civil disputes has received growing attention.¹ While apologies may well play a role in resolving civil disputes generally,² they may be particularly relevant in the health care setting—a setting in which the parties are in a relationship that necessitates a high degree of trust and intimacy.³ Apology is, after all, consistent with a professional ethic that cares for and respects patients. In addition, there is evidence that patients desire apologies after medical errors and that physicians desire to give apologies.⁴ Physicians, however, are apprehensive that disclosing errors and apologizing for them will result in lawsuits and

* Associate Dean for Faculty Research and Development and Associate Professor of Law, University of Missouri-Columbia School of Law. Thanks to Jay Hastings for research assistance and to the University of Missouri Law School Foundation for financial support.

1. See, e.g., Jonathan R. Cohen, *Advising Clients to Apologize*, 72 S. CAL. L. REV. 1009 (1999) [hereinafter *Advising Clients to Apologize*]; Jonathan R. Cohen, *Legislating Apology: The Pros and Cons*, 70 U. CIN. L. REV. 819 (2002) [hereinafter *Legislating Apology*]; Erin Ann O'Hara & Douglas Yarn, *On Apology and Consilience*, 77 WASH. L. REV. 1121 (2002); Aviva Orenstein, *Apology Excepted: Incorporating a Feminist Analysis into Evidence Policy Where You Would Least Expect It*, 28 SW. U. L. REV. 221 (1999); Jennifer K. Robbennolt, *Apologies and Legal Settlement: An Empirical Examination*, 102 MICH. L. REV. 460 (2003); Daniel Shuman, *The Role of Apology in Tort Law*, 83 JUDICATURE 180 (2000); Lee Taft, *Apology Subverted: The Commodification of Apology*, 109 YALE L.J. 1135 (2000).

2. See *Advising Clients to Apologize*, *supra* note 1, at 1031; Robbennolt, *supra* note 1, at 461.

3. See Marlynn L. May & Daniel B. Stengel, *Who Sues Their Doctors? How Patients Handle Medical Grievances*, 24 LAW & SOC'Y REV. 105, 110 (1990) ("[T]he patient/doctor connection is unique in the 'personal' bond that links the parties. The doctor is dealing with the patient's body and health and may literally hold the life of the patient in his/her hands."); C.A. Vincent & A. Coulter, *Patient Safety: What About the Patient?* 11 QUALITY SAFE HEALTH CARE 76, 78 (2002) (noting that "patients have been harmed, unintentionally, by people in whom they placed considerable trust" and that then "they are often cared for by the same professions, and perhaps the same people, as those involved in the original injury.").

4. See *infra* Part II.

loss of respect and trust by patients and peers.⁵ Perhaps it is not surprising that the issue of whether or not health care providers should consider apologizing in the wake of a medical error is increasingly being explored and debated in the medical literature,⁶ the legal literature,⁷ and the popular press.⁸

Much of the discussion of how apologies might be beneficial in resolving health care disputes has been based primarily on intuition and incomplete empirical data. This Article attempts to review what is known and not known about apologies in this context. After briefly reviewing, in Part I, some recent legislative developments regarding disclosing and apologizing for medical errors, Part II describes what is known about apologies in health care disputes. This Part brings together and examines a variety of empirical data—from surveys, experiments, and case studies—that bear on the role of apologies in health care settings. Part III draws attention to avenues of further research.

I. LEGISLATIVE DEVELOPMENTS

Whether and how to communicate with patients about medical error has drawn much recent interest. Several states now require that

5. See Thomas H. Gallagher et al., *Patients' and Physicians' Attitudes Regarding the Disclosure of Medical Errors*, 289 JAMA 1001, 1003 (2003). The fear of malpractice litigation is the barrier to disclosure most frequently cited by risk managers. See Rae M. Lamb et al., *Hospital Disclosure Practices: Results of a National Survey*, 22 HEALTH AFF. 73, 78 (2003) (reporting that 77% of survey respondents cited this barrier).

6. See e.g., Douglas N. Frenkel & Carol B. Liebman, *Words that Heal*, 140 ANNALS INTERNAL MED. 482 (2004); Steve S. Kraman, *A Risk Management Program Based on Full Disclosure and Trust: Does Everyone Win?*, 27 COMPREHENSIVE THERAPY 253, 254 (2001); Charles Vincent et al., *Why Do People Sue Doctors? A Study of Patients and Relatives Taking Legal Action*, 343 LANCET 1609 (1994); Amy B. Witman et al., *How Do Patients Want Physicians to Handle Mistakes? A Survey of Internal Medicine Patients in an Academic Setting*, 156 ARCHIVES INTERNAL MED. 2565 (1996).

7. See e.g., Jonathan R. Cohen, *Apology and Organizations: Exploring an Example from Medical Practice*, 27 FORDHAM URB. L.J. 1447 (2000) [hereinafter *Apology and Organizations*]; Erin Ann O'Hara, *Apology and Thick Trust: What Spouse Abusers and Negligent Doctors Might Have in Common*, 79 CHI.-KENT L. REV. 1055 (2004).

8. See, e.g., Andrea Gerlin, *Accepting Responsibility by Policy*, PHILA. INQUIRER, Sept. 14, 1999, at A18; John Nance, *A Tragic Error, and a Laudable Response*, SEATTLE POST-INTELLIGENCER, Dec. 12, 2004, at F1; Lindsey Tanner, *Doctors Eye Apologies for Medical Mistakes*, ASSOCIATED PRESS, Nov. 8, 2004; Rachel Zimmerman, *Medical Contrition: Doctors' New Tool To Fight Lawsuits: Saying 'I'm Sorry'*, WALL ST. J., May 18, 2004, at A1.

hospitals or physicians disclose to patients that an adverse outcome has occurred. For example, Pennsylvania requires that “[a] medical facility . . . shall provide written notification to a patient affected by a serious event . . . within seven days of the occurrence or discovery of a serious event.”⁹ Florida requires facilities to “inform each patient . . . in person about adverse incidents that result in serious harm to the patient.”¹⁰ Using different terminology, Nevada provides that a representative of the medical facility “shall, not later than 7 days after discovering or becoming aware of a sentinel event that occurred at the medical facility, provide notice of that fact to each patient who was involved in that sentinel event.”¹¹ In addition, New Jersey requires that a patient be informed of “a serious preventable adverse event or an adverse event specifically related to an allergic reaction” in a “timely fashion.”¹²

These disclosure provisions are consistent with ethical standards articulated by a number of professional medical organizations. For example, the American College of Physicians’ Ethics Manual provides that “physicians should disclose to patients information about procedural or judgment errors made in the course of care if such information is material to the patient’s well-being. Errors do not necessarily constitute improper, negligent, or unethical behavior, but failure to disclose them may.”¹³ Similarly, the American Medical Association (AMA) instructs physicians that when “a patient suffers significant medical complications that may have resulted from the physician’s mistake or judgment, . . . the physician is ethically

9. 40 PA. CONS. STAT. ANN. § 1303.308(b) (West 2004). The statute further provides that “[n]otification under this subsection shall not constitute an acknowledgment or admission of liability.” *Id.*

10. FLA. STAT. ANN. § 395.1051 (West 2005). Like Pennsylvania, Florida affords protection for these disclosures, providing that “[n]otification of outcomes of care that result in harm to the patient under this section shall not constitute an acknowledgment or admission of liability, nor can it be introduced as evidence.” *Id.* See also FLA. STAT. ANN. § 395.0197 (West 2005) (requiring that health care facilities implement “a system for informing a patient . . . that the patient was the subject of an adverse incident . . . as soon as practicable to allow the patient an opportunity to minimize damage or injury”).

11. NEV. REV. STAT. 439.855 (2004).

12. N.J. STAT. ANN. § 26:2H-12.25(d) (West 2004).

13. AM. COLL. OF PHYSICIANS, ETHICS MANUAL (4th ed. 1998), available at <http://www.acponline.org/ethics/ethicman.htm>.

required to inform the patient of all the facts necessary to ensure understanding of what has occurred.”¹⁴ Moreover, the AMA counsels that “[c]oncern regarding the legal liability which might result following truthful disclosure should not affect the physician’s honesty with a patient.”¹⁵

However, neither the ethical guidelines nor the statutory disclosure requirements themselves equip providers with guidance about how the disclosure ought to be made.¹⁶ Health care providers have received varied advice, compounding the uncertainty. Consistent with providers’ fears of litigation, risk managers, insurance companies, and others have advised providers against disclosure or apology.¹⁷ Alternately, providers sometimes are advised to acknowledge the outcome and express sympathy, but to avoid any discussion of responsibility.¹⁸ Others, often suggesting that an approach that fails to acknowledge responsibility can make matters worse,¹⁹ advise providers to discuss errors with patients, offer apologies, and make compensation.²⁰ Not surprisingly, a recent survey of hospital risk

14. AM. MED. ASS’N, POLICY E-8.12: PATIENT INFORMATION (1994), available at http://www.ama-assn.org/apps/pf_new/pf_online?f_n=browse&doc=policyfiles/HnE/E-8.12.HTM.

15. *Id.*

16. The National Patient Safety Foundation provides a somewhat more explicit recommendation in this regard:

When a health care injury occurs, the patient . . . [is] entitled to a prompt explanation of how the injury occurred and its short- and long-term effects. When an error contributed to the injury, the patient . . . should receive a truthful and compassionate explanation about the error and the remedies available to the patient. They should be informed that the factors involved in the injury will be investigated so that steps can be taken to reduce the likelihood of similar injury to other patients.

NAT’L PATIENT SAFETY FOUND., TALKING TO PATIENTS ABOUT HEALTH CARE INJURY: STATEMENT OF PRINCIPLE (2001), available at <http://www.npsf.org/html/statement.html>; see also Carol B. Liebman & Chris Stern Hyman, *A Mediation Skills Model to Manage Disclosure of Errors and Adverse Events to Patients*, 23 HEALTH AFF. 22, 25-28 (2004) (discussing these “disclosure conversations”).

17. See STEPHEN B. GOLDBERG ET AL., DISPUTE RESOLUTION 138 (1992); Gallagher et al., *supra* note 5; Robert L. Lowes, *Made a Bonehead Mistake? Apologize*, 74 MED. ECON. 94 (1997).

18. See, e.g., Janine Fiesta, *Communication—The Value of an Apology*, 25 NURSING MGMT. 14 (1994) (advising nursing managers that the “value of an apology without any admission of fault goes a long way” and that the “healthcare provider should never admit liability”).

19. See Daniel Finkelstein et al., *When a Physician Harms a Patient by a Medical Error: Ethical, Legal, and Risk-Management Considerations*, 8 J. CLINICAL ETHICS 330, 333-34 (1997) (“[W]ording disclosure in a way that would acknowledge the bad outcome without admitting guilt or assuming blame . . . would run counter to the ethical principle of respect for persons.”).

20. See *id.* at 333; Daniel O’Connell et al., *Disclosing Unanticipated Outcomes and Medical Errors*, 10 J. CLINICAL OUTCOME MGMT. 25 (2003); Vincent & Coulter, *supra* note 3, at 78.

managers found “marked variation” among hospitals in disclosure practices.²¹ While most risk managers reported that when they make a disclosure they include an explanation (92%) and would initiate an investigation into the occurrence (87%), fewer reported that they include an apology (68%), that they accept responsibility for the harm (33%), or that they pay compensation (36%).²² Moreover, risk managers’ intuitions varied about whether disclosure would increase or decrease the risk of litigation.²³

Of particular interest for the purposes of this Article is the role of apology in these disclosure conversations. Indeed, at the same time that there has been growing interest in disclosure requirements, a number of states have enacted statutes designed to encourage apologies by preventing parties from using them as evidence at trial. For example, an Oregon statute provides that “any expression of regret or apology made by or on behalf of [a licensed medical provider] . . . does not constitute an admission of liability for any purpose” and may not be the subject of examination “by deposition or otherwise.”²⁴ Oklahoma recently enacted a statute that protects some apologetic statements from being admissible in medical malpractice cases. The Oklahoma statute provides:

A. In any medical liability action, any and all statements, affirmations, gestures, or conduct expressing apology, sympathy, commiseration, condolence, compassion, or a general sense of benevolence which are made by a health care provider or an employee of a health care provider to the plaintiff, a relative of the plaintiff, or a representative of the plaintiff and which relate solely to discomfort, pain, suffering, injury, or death as the result of the unanticipated outcome of the medical care shall be

21. See Lamb et al., *supra* note 5, at 81.

22. *Id.* at 77.

23. *Id.* at 78. Thirty-seven percent thought that disclosure increased malpractice risk, 33% thought that disclosure decreased malpractice risk, and 25% thought that disclosure did not affect malpractice risk. *Id.*

24. OR. REV. STAT. §§ 677.082(1)-(2) (2003).

inadmissible as evidence of an admission of liability or as evidence of an admission against interest.²⁵

Statutes in Ohio and Wyoming contain similar provisions.²⁶ These provisions are similar to statutes in a number of other states that are applicable, not just in medical malpractice cases, but in civil actions more generally.²⁷ Many of these statutes, however, preserve the admissibility of statements that acknowledge fault.²⁸ Colorado has chosen to explicitly protect statements that acknowledge fault, providing protection in medical malpractice suits, to “any and all statements, affirmations, gestures, or conduct expressing apology, fault, sympathy, commiseration, condolence, compassion, or a general sense of benevolence” offered by health care providers.²⁹ Similarly, Georgia provides protection to “any and all statements affirmations, gestures, activities or conduct expressing benevolence, regret, apology, sympathy, commiseration, condolence, compassion, mistake, error, or a general sense of benevolence which are made by a health care provider.”³⁰

Proponents of these statutes suggest that if the law protects apologetic expressions from admissibility, health care providers and other defendants will be more likely to offer them. It is further

25. OKLA. STAT. ANN. tit. 63, § 1-1708.1H (West 2005).

26. OHIO REV. CODE ANN. § 2317.43 (West 2005); WYO. STAT. ANN. § 1-1-130 (West 2005)

27. See, e.g., FLA. STAT. ANN. § 90.4026(2) (West 2005). The Florida statute provides:

The portion of statements, writings, or benevolent gestures expressing sympathy or a general sense of benevolence relating to the pain, suffering, or death of a person involved in an accident and made to that person or to the family of that person shall be inadmissible as evidence in a civil action. A statement of fault, however, which is part of, or in addition to, any of the above shall be admissible pursuant to this section.

Id.; see also WASH. REV. CODE ANN. § 5.66.010(1) (West 2005); CAL. EVID. CODE § 1160(a) (West 1995); TEX. CIV. PRAC. & REM. § 18.061 (Vernon 2004). In the absence of such protection (and unless offered in the context of settlement negotiation or in mediation), an apology is likely to be admissible as a party's own statement, an exception to the hearsay rule. FED. R. EVID. 801(d)(2); see also *Legislating Apology*, *supra* note 1 (discussing the benefits and drawbacks of statutes that exclude evidence of apology); Robbenolt, *supra* note 1, at 465-67 (discussing the admissibility of apologies).

28. See, e.g., FLA. STAT. ANN. § 90.4026(2) (West 2005).

29. COLO. REV. STAT. § 13-25-135 (2004).

30. S.B. 3, 150th Gen. Assem., Reg. Sess. (Ga. 2005), available at http://www.legis.state.ga.us/legis/2005_06/fulltext/sb3.htm (last visited Apr. 1, 2005). The bill was signed by the Governor on February 21, 2005. *SB 3 Bill History*, Georgia General Assembly, at http://www.legis.state.ga.us/legis/2005_06/sum/sb3.htm (last visited Apr. 1, 2005).

anticipated that apologies, if offered, will lead to a variety of legal and non-legal benefits to disputants. Specifically, proponents suggest that apologies play a role in repairing relationships, have positive emotional and physiological benefits, fulfill a need to make reparations and restore equity, make forgiveness possible, and facilitate psychological growth.³¹ Accordingly, apologies may facilitate settlement by making possible better, faster, more satisfying negotiations. In the health care context, proponents hope that apologies will also lead to better relationships and increased trust between patients and health care providers, the alleviation of suffering for both patients and providers, and an increased ability to learn from mistakes and prevent future errors.³²

While there is a body of research spanning several disciplines suggesting positive impacts of apologizing more generally,³³ only recently has there been systematic research examining the role of apology in litigation and, more specifically, the role of disclosure and apology in cases of adverse medical outcomes.

II. WHAT WE KNOW: EMPIRICAL RESEARCH

A. Survey Research

Several studies have examined the reasons that litigants in medical malpractice cases cite for why they brought a lawsuit. Patients, it

31. See, e.g., Michael E. McCullough et al., *Interpersonal Forgiving in Close Relationships*, 73 J. PERSONALITY & SOC. PSYCHOL. 321 (1997); Elaine Walster et al., *New Directions in Equity Research*, 25 J. PERSONALITY & SOC. PSYCHOL. 151 (1973); Gerald R. Williams, *Negotiation as a Healing Process*, 1996 J. DISP. RESOL. 1, 53; Charlotte Witvliet et al., *Victims' Heart Rate and Facial EMG Responses to Receiving an Apology and Restitution*, PSYCHOPHYSIOLOGY 588 (2002).

32. See Finkelstein et al., *supra* note 19, at 332; Vincent & Coulter, *supra* note 3, at 78. See generally Albert W. Wu, *To Tell the Truth: Ethical and Practical Issues in Disclosing Medical Mistakes to Patients*, 12 J. GEN. INTERNAL MED. 770 (1997) (discussing the potential costs and benefits to patients and physicians of disclosing medical errors).

33. See, e.g., Bruce W. Darby & Barry R. Schlenker, *Children's Reactions to Apologies*, 43 J. PERSONALITY & SOC. PSYCHOL. 742, 746, 749 (1982); Gregg J. Gold & Bernard Weiner, *Remorse, Confession, Group Identity, and Expectancies About Repeating a Transgression*, 22 BASIC & APPLIED SOC. PSYCHOL. 291 (2000); Ken-ichi Ohbuchi et al., *Apology as Aggression Control: Its Role in Mediation Appraisal and Response to Harm*, 56 J. PERSONALITY & SOC. PSYCHOL. 219 (1989); Steven J. Scher & John M. Darley, *How Effective Are the Things People Say to Apologize? Effects of the Realization of the Apology Speech Act*, 26 J. PSYCHOLINGUISTIC RES. 127, 134-35 (1997); Bernard Weiner et al., *Public Confession and Forgiveness*, 50 J. PERSONALITY 281, 291 (1991).

turns out, report a variety of motivations for filing suit after an injury, several of which indicate the potential importance of disclosure and apology. In particular, many patients say that they file lawsuits to get information about and understand their injury and the circumstances surrounding it, to determine accountability, and to prevent future injuries.

Gerald Hickson and his colleagues conducted interviews with 127 family members who filed claims against medical providers for perinatal injuries.³⁴ Family members cited a number of reasons for filing suit, some of which relate to disclosure and apology.³⁵ Twenty-four percent of those interviewed said that they chose to file suit “when they realized that physicians had failed to be completely honest with them about what happened, allowed them to believe things that were not true, or intentionally misled them.”³⁶ In addition, 20% of those interviewed filed suit “when they decided that the courtroom was the only forum in which they could find out what happened from the physicians who provided care.”³⁷ Nineteen percent indicated that a motivation for filing was the need to achieve deterrence or retribution, including not wanting the physician to continue to provide substandard care.³⁸

In a similar study of medical claims, Charles Vincent and his colleagues asked claimants about any explanation they had received following the injury, why they brought the claim, and what could have prevented their claim.³⁹ Although the need for communication and an explanation was one of the key reasons claimants gave for filing suit, receiving an explanation for the adverse event was not the norm—over one-third (37%) of claimants received no explanation, and only 21% received an explanation within a few days.⁴⁰ Of those

34. Gerald B. Hickson et al., *Factors that Prompted Families to File Medical Malpractice Claims Following Perinatal Injuries*, 267 JAMA 1359 (1992).

35. *Id.* at 1361.

36. *Id.*

37. *Id.*

38. *Id.*

39. See generally Vincent et al., *supra* note 6.

40. See *id.* at 1611. An additional 12% received an explanation within a few weeks, 16% received an explanation within one year, and approximately 7% received an explanation more than one year later. *Id.* A study of depositions in cases against a large health care system found that approximately 10% of the

who did receive an explanation, fewer than 40% felt that the provider gave the explanation in a sympathetic manner.⁴¹ Medical care providers accepted responsibility for the adverse outcome, either wholly or in part, in only 13% of cases.⁴² Nearly 40% of claimants who thought that something could have been done to prevent litigation indicated that litigation would not have been necessary if the medical provider had offered an explanation and apologized.⁴³

The results of both of these studies are consistent with those of Marlynn May and Daniel Stengel, who conducted interviews with discontented patients, some of whom filed lawsuits and others who did not.⁴⁴ They found a correlation between dissatisfaction with the interaction between the patient and physician in the aftermath of the adverse event and the likelihood of turning to an attorney for assistance.⁴⁵ Similarly, the finding that many patients report that difficulties stemming from a lack of disclosure or apology motivate them to sue is consistent with studies finding a relationship between communication problems with the physician more generally and whether patients will sue.⁴⁶

deponents mentioned a failure to explain. Howard B. Beckman, *The Doctor-Patient Relationship and Malpractice: Lessons from Plaintiff Depositions*, 154 ARCHIVES INTERNAL MED. 1365, 1367 (1994).

41. Vincent et al., *supra* note 6, at 1611. Most explanations were "felt to be unclear, inaccurate, and lacking information." *Id.*

42. *Id.*

43. *Id.* at 1612. Attorneys' beliefs appear to be consistent with those of patients in this regard. See Roy Penchansky & Carol Macnee, *Initiation of Medical Malpractice Suits: A Conceptualization and Test*, 32 MED. CARE 813, 828 (1994) (finding that attorneys believed that when a physician "explains diagnosis and treatment and [is] responsive to questions," it decreases a patient's willingness to sue).

44. See May & Stengel, *supra* note 3, at 106.

45. *Id.* at 116-17.

46. See, e.g., Beckman, *supra* note 40, at 1367-68; Hickson et al., *supra* note 34, at 1361; LaRae I. Huycke & Mark M. Huycke, *Characteristics of Potential Plaintiffs in Malpractice Litigation*, 120 ANNALS INTERNAL MED. 792, 797 (1994); Gregory W. Lester & Susan G. Smith, *Listening and Talking to Patients: A Remedy for Malpractice Suits?*, 158 W. J. MED. 268, 270 (1993); Wendy Levinson et al., *Physician-Patient Communication: The Relationship with Malpractice Claims Among Primary Care Physicians and Surgeons*, 277 JAMA 553, 557-58 (1997); Robyn S. Shapiro et al., *A Survey of Sued and Nonsued Physicians and Suing Patients*, 149 ARCHIVES INTERNAL MED. 2190, 2192-93 (1989); see also T. Elaine Adamson et al., *Physician Communication Skills and Malpractice Claims: A Complex Relationship*, 150 W. J. MED. 356 (1989) (assessing "the relationship between patients' opinion about their physicians' communication skills and the physician's history of medical malpractice claims"). Studies of complaints also suggest a relationship between communication and lawsuits. See, e.g., Gerald B. Hickson et al., *Patient Complaints and Malpractice Risk*, 287 JAMA 2951, 2957 (2002).

Using a different methodology, Thomas Gallagher and his colleagues conducted focus groups with patients and physicians to discuss medical error and found interesting differences in how patients and physicians viewed medical error.⁴⁷ Patients desired full disclosure (including “what happened, the implications of the error for their health, why it happened, how the problem will be corrected, and how future errors will be prevented”), desired apologies, and wanted information to “be provided to them rather than having to ask their physician numerous questions.”⁴⁸ Patients expressed a desire for reassurance that the provider felt regret and that the provider would make the appropriate changes to prevent recurrence of the error.⁴⁹ Physicians reported a desire to apologize but also reported concern that disclosure increased the possibility for legal liability. As a result, they reported choosing their words carefully and a belief that, if patients wanted more information or an explanation, they “would ask follow-up questions.”⁵⁰ This basic disconnect between patients and physicians can be counter-productive. Patients in the study reported that “they would be less upset if the physician disclosed the error honestly and compassionately and apologized . . . [and] . . . that explanations of the error that were incomplete or evasive would increase their distress.”⁵¹

B. Experiments

Experimental studies have also explored the effects of disclosure or apology in the context of litigation—several of them in the medical malpractice context.

Amy Witman and her colleagues presented 149 patients with hypothetical descriptions of medical errors that resulted in injuries of varying degrees.⁵² They found that, regardless of the severity of the

47. Gallagher et al., *supra* note 5, at 1001.

48. *Id.* at 1004.

49. *Id.*

50. *Id.* at 1003, 1004 & tbl 2.

51. *Id.* at 1005. *See generally* Shapiro et al., *supra* note 46, at 2190 (finding differences in the perceived reasons that patients file medical malpractice suits among claimants, sued physicians, and non-sued physicians).

52. Witman et al., *supra* note 6, at 2565.

injury, 98% of the patients “desired or expected the physician’s active acknowledgement of an error. This ranged from a simple acknowledgement of the error to various forms of apology.”⁵³ In addition, patients were more likely to indicate that they would change physicians, report the physician, or file a lawsuit if the physician failed to inform them of the error than if they were informed.⁵⁴ These experimental findings are consistent with the surveys of litigants reported above—patients say that they want disclosure and apologies.

Kathleen Mazor and her colleagues conducted an experimental study of health care plan members’ responses to medication errors.⁵⁵ Respondents read one version of a set of written vignettes describing a medical error and the physician’s response.⁵⁶ In the “nondisclosure” conditions, the physician provided limited information about the error and did not acknowledge responsibility.⁵⁷ In the “full disclosure” conditions, the physician provided more information, took responsibility for the error, apologized, and detailed steps that would be taken to prevent recurrence.⁵⁸ Patients who read the full disclosure vignettes were less likely to indicate that they would seek legal advice in response to the incident than patients who read the nondisclosure versions.⁵⁹ Respondents in the full disclosure conditions were also less likely to indicate that they would change physicians, and reported more satisfaction, more trust in the physician, and fewer negative emotions than those in the nondisclosure conditions.⁶⁰ When asked to report on their preferences for what a provider should do following a medical error, 88% of the respondents agreed with the statement “I would want the doctor to

53. *Id.*

54. *Id.*

55. See Kathleen M. Mazor et al., *Health Plan Members’ Views About Disclosure of Medical Errors*, 140 ANNALS INTERNAL MED. 409, 409 (2004).

56. *Id.* at 410.

57. See *id.* at 411 fig. 1.

58. *Id.*

59. *Id.* at 413. For each type of error and level of injury fewer of those in the full disclosure condition than in the nondisclosure condition indicated that they would seek legal advice. However, this pattern was only statistically significant for the condition in which the error was a missed medication allergy and the outcome was less severe. *Id.*

60. *Id.* at 414.

tell me that he or she was sincerely sorry,” and 99% of the respondents agreed with the statement “I would want to know that something was being done to make sure it didn’t happen to someone else.”⁶¹

Ronald McCord and his colleagues asked patients in a family practice clinic to watch a series of videotapes displaying a dispute between a patient and a physician over the length of the patient’s wait time.⁶² Each version of the interaction displayed a different response by the physician, including several types of apology or explanation.⁶³ Patients reported the highest levels of satisfaction with physician responses that involved an apology that implied a taking of responsibility and an apology coupled with an explanation of the reason for the wait.⁶⁴ Patients ranked an apology as the most important statement that a physician can give, followed in importance by an explanation.⁶⁵ When asked to write a script for what they would like the physician to say in response to the patient’s anger, 77% of the participants mentioned an apology, and 47% mentioned an explanation.⁶⁶

Finally, Jennifer Robbennolt conducted a series of experimental studies that examined the effects of apologies on settlement decision-making in a non-medical context.⁶⁷ Participants read a vignette describing a pedestrian-bicycle accident from the perspective of the injured party and evaluated a settlement offer from the other party.⁶⁸ Apologies that accepted responsibility had a positive impact on settlement decision-making, resulting in favorable effects on the injured party’s attributions about the situation and the other party and in an increased tendency for recipients to accept the settlement

61. *Id.* at 415.

62. Ronald S. McCord et al., *Responding Effectively to Patient Anger Directed at the Physician*, 34 COMM. TECH. & BEHAV. 331, 332 (2002).

63. *Id.* at 333 tbl. 1.

64. *Id.*

65. *Id.* at 334.

66. *Id.*

67. See Robbennolt, *supra* note 1, at 462-63.

68. *Id.* at 484-85.

offer.⁶⁹ Participants who received a full apology saw the other party as more regretful, more moral, more likely to act carefully in the future, and as having behaved less badly than those who did not receive a full apology.⁷⁰ Participants who received a full apology also experienced greater sympathy for the other party, less anger, and more willingness to forgive, and believed that the incident would result in less damage to the parties' relationship.⁷¹

Robbennolt also examined the effects of offering an expression of sympathy without an admission of fault.⁷² In contrast to the effects of apologies that accepted responsibility, sympathy expressions did not have the same overall impacts on attributions and appeared to increase participants' uncertainty about whether or not to accept the offer.⁷³ Instead, the effects of sympathy expressions appear to be more dependent on a variety of contextual factors such as the severity of the injury or the extent to which the other party was responsible for the harm.⁷⁴

C. Case Study

Finally, there are case studies of institutions that have adopted policies of disclosure or apology. The Veterans Affairs (VA) Medical Center in Lexington, Kentucky ("Lexington VA") has implemented the most widely described policy of this nature.⁷⁵ As described by Jonathan Cohen:

69. *Id.* at 487-88; see also Russell Korobkin & Chris Guthrie, *Psychological Barriers to Litigation Settlement: An Experimental Approach*, 93 MICH. L. REV. 107, 147-50 (1994) (describing a similar study and concluding that a disputant who feels that he or she has been treated equitably is less likely to seek vindication in court).

70. Robbennolt, *supra* note 1, at 487.

71. *Id.* at 488.

72. *Id.* at 494-99.

73. *Id.* at 496-97.

74. *Id.* at 498-99.

75. See generally *Apology and Organizations*, *supra* note 7; Gerlin, *supra* note 8; Kraman, *supra* note 6; Steve S. Kraman & Ginny Hamm, *Risk Management: Extreme Honesty May Be the Best Policy*, 131 ANNALS INTERNAL MED. 963 (1999); Albert W. Wu, *Handling Hospital Errors: Is Disclosure the Best Defense?*, 131 ANNALS INTERNAL MED. 970 (1999).

The policy involved multiple steps. The hospital encouraged workers to report mistakes to its risk management committee. . . . Once a mistake was reported, a typical case proceeded as follows. The committee rapidly investigated the mistake and attempted to determine its root cause. If the root cause was deemed “systemic,” efforts at systemic reform were undertaken. If the mistake resulted in harm to the patient, irrespective of whether the patient was aware of it, the patient was informed of the error. In some cases, the patient was not aware nor likely would have become aware of the mistake absent the hospital volunteering the information. The risk management committee then brainstormed about ways to aid the patient through further medical treatment, disability benefits, and compensation. The committee arranged a meeting between itself, the patient and anyone the patient wished to bring, usually family members and an attorney. If the risk management committee believed that the hospital or its employees had been at fault, [the chief of staff and chair of the risk management committee] apologized to the patient at that meeting, including admitting fault verbally and, if the patient desired, subsequently in writing. Members of the committee then discussed further steps the hospital could take to aid the patient medically and any disability benefits to which the patient might be entitled. In cases where the risk management committee believed the hospital or its employees had been at fault, the committee made what it believed to be a fair settlement offer.⁷⁶

As a part of the policy, the hospital refuses to settle claims that the committee determines to be without merit.⁷⁷

The hospital has reported that with the policy in place, patients are less angry and continue to have a good relationship with the hospital, cases settle more quickly, self-reporting of errors by the medical professionals has increased, the hospital has received positive

76. *Apology and Organizations*, *supra* note 7, at 1452-53.

77. Kraman, *supra* note 6, at 256.

publicity, and litigation costs have declined.⁷⁸ In addition, the hospital compared itself to 35 comparable VA hospitals for a seven-year period following implementation of the policy. The Lexington hospital was in the top 20% of facilities in terms of the number of claims against it (possibly reflecting the fact that more patients learn of errors) but was among the lowest 25% of facilities in terms of the amount of total payments.⁷⁹

There are a number of factors that make it difficult to generalize from the experience in Lexington to health care settings more generally. For example, the VA is not subject to punitive damages, the providers' personal liability exposure in the system differs from that of providers in the private sector, and the patients are not representative of the broader population and may have access to additional sources of compensation.⁸⁰ Moreover, it is difficult to disentangle the effects of portions of the policy, such as disclosing, apologizing, or offering compensation, from the effects of the policy as a whole.⁸¹ Nonetheless, the Lexington VA experience stands as one example of the potential effects of implementing a policy of disclosure that includes apology.⁸²

III. UNANSWERED QUESTIONS

The research reviewed here suggests that apology has a role to play in the resolution of health care disputes. Survey research finds that patients report that they desire apologies, and that they may have been less likely to litigate if the other party had apologized.⁸³ Experimental studies indicate that litigants may be more likely to make favorable attributions, less likely to seek legal counsel, and more likely to settle when they receive apologies.⁸⁴ Researchers

78. *Id.* at 255.

79. Kraman & Hamm, *supra* note 75, at 965-66.

80. *Apology and Organizations*, *supra* note 7, at 1455-56; Wu, *supra* note 75, at 971.

81. *Apology and Organizations*, *supra* note 7, at 1455-56.

82. See, e.g., Daniel A. Pietro et al., *Detecting and Reporting Medical Errors: Why the Dilemma?*, 320 BRITISH MED. J. 794 (2000) (describing another hospital's experience).

83. See *supra* Part II.A-B.

84. See *supra* Part II.B.

continue to explore the boundaries on these effects. The experiences of individual facilities seem to suggest that providers can incorporate disclosure and apology in policies addressing adverse events without ill effects. There is, however, still much to be learned.

It is clear that the role of apologies in resolving health care disputes is complex. There are risks to apologizing—the patient may sue anyway, and an apology (particularly one that accepts responsibility) may make the patient's case easier to prove. Moreover, an inadequate or poorly delivered apology may incite the patient's ire by adding insult to injury and, itself, lead to litigation.⁸⁵ Providers must balance these risks against the potential for an apology to help repair relationships, to smooth the resolution of the dispute, or to make it harder to portray the provider as a villain if a lawsuit does go forward.⁸⁶ On the other hand, there are also risks to not apologizing; failure to apologize and take responsibility when appropriate may be unsatisfying to the provider, may result in increased anger and blame, and may provide the patient with a reason to sue. We know very little about how most of these possibilities are likely to play out; a few examples are highlighted below.

First, while the research suggests that apologies are likely to result in generally positive effects, there is much we do not know about how different personal and situational factors may impact these effects. For example, one might draw a distinction between medical errors and adverse outcomes that are not attributable to error.⁸⁷ This distinction may have important implications for how patients respond to apologies. In particular, the existing research seems to suggest that the degree of responsibility attributed to the other party moderates how injured parties respond to expressions of sympathy.⁸⁸ Thus, it may be that when there has been a medical error, a responsibility accepting apology is most powerful but that an expression of

85. See Liebman & Hyman, *supra* note 16, at 25 (“[The] consequences of doing [disclosure] badly can be severe: breakdown in relationships, failure to prevent future error, increased emotional stress, and litigation.”); Lowes, *supra* note 17 (“You may apologize in a way that increases the likelihood of a suit.”).

86. Lowes, *supra* note 17, at 101.

87. See Liebman & Hyman, *supra* note 16, at 23; O'Connell et al., *supra* note 20, at 26.

88. See *supra* Part II.B.

sympathy is helpful when an adverse outcome occurs but is not the result of an error.⁸⁹ Complicating this relationship, moreover, are a host of factors that may influence how patients and providers may attribute responsibility for an adverse outcome.⁹⁰ Understanding how patients and providers distinguish between adverse outcomes that are and are not attributable to error may help us to better understand the role of apologies in resolving these disputes.

Second, there is little empirical research exploring factors related to the content and delivery of the apology. The research suggests that there is wide variety in what providers include in disclosure conversations, and it would not be surprising if there were also wide variation in how different providers deliver apologies across different situations. It may also be the case that providers who hope and intend to deliver meaningful apologies may not have the communication skills to implement those intentions. We know very little, for example, about the influence of the timing of the apology,⁹¹ who delivers the apology (e.g., a physician or someone representing the institution), or whether the provider offers the apology in the context of a mediation.⁹² Similarly, the existing research has not carefully examined how the various components of the conversation interrelate.⁹³ Future research might explore how apologies operate in the context of other possible components of the discussion, such as

89. See O'Connell et al., *supra* note 20, at 27 (advising providers to give an explanation and express sympathy for an unanticipated outcome with no medical error and to apologize and take responsibility when there has been an error that results in an adverse outcome).

90. See generally Frank D. Fincham & Joseph M. Jaspars, *Attribution of Responsibility: From Man the Scientist to Man as Lawyer*, 13 ADVANCES EXPERIMENTAL SOC. PSYCHOL. 81 (1980); see also Lowes, *supra* note 17 (noting that, "in many situations, what may look like a mistake in the patient's eyes isn't really a mistake—and so shouldn't be treated as such or apologized for.").

91. But see Cynthia McPherson Franz & Courtney Bennigson, *Better Late Than Early: The Influence of Timing on Apology Effectiveness*, 41 J. EXPERIMENTAL SOC. PSYCHOL. 201 (2005).

92. See *supra* Part II. For discussion of mediation in health care disputes see Edward A. Dauer, *A Therapeutic Jurisprudence Perspective on Legal Responses to Medical Error*, 24 J. LEGAL MED. 37 (2003); Edward A. Dauer & Leonard J. Marcus, *Adapting Mediation to Link Resolution of Medical Malpractice Disputes with Health Care Quality Improvement*, 60 LAW & CONTEMP. PROBS. 185 (1997); Edward A. Dauer et al., *Prometheus and the Litigators: A Mediation Odyssey*, 21 J. LEGAL MED. 159 (2000); Ann J. Kellett, Comment, *Healing Angry Wounds: The Roles of Apology and Mediation in Disputes Between Physicians and Patients*, 1987 J. DISP. RESOL. 111; Liebman & Hyman, *supra* note 16. See generally Deborah L. Levi, Note, *The Role of Apology in Mediation*, 72 N.Y.U. L. REV. 1165 (1997).

93. But see Scher & Darley, *supra* note 33.

disclosure, an explanation, an offer of compensation, discussion of prevention efforts, and so on.

Third, some have expressed concerns that an apology may induce injured parties to settle for too little compensation. Arguments that health care providers offering insincere apologies can manipulate injured parties into agreeing to inadequate settlements magnify these concerns.⁹⁴ In this vein, Erin O'Hara has argued that the "dependency and trust" attendant to the patient-physician relationship predisposes patients to accept apologies from physicians too easily.⁹⁵ Additional research should examine the ways in which injured patients respond to apologies of different types and how those responses influence settlement outcomes.

Finally, health care providers cite fear of litigation as a major barrier to disclosing and apologizing for medical error.⁹⁶ Statutes that prevent apologies from being admissible at trial speak to this fear and are premised and promoted on the notion that apologies will be more forthcoming if the law provides this protection. However, whether these apology statutes will result in more apologies is an open empirical question. These statutes provide opportunities to explore the influences on providers' willingness to offer apologies and on insurance companies, risk managers, and defense attorneys' willingness to advise clients to consider apologizing. Research might also explore how these statutes may influence perceptions of the risks and benefits of apologizing—these perceptions may well be more important than the realities in influencing behavior. Beyond this, however, it seems clear that part of the fear of litigation stems from

94. See generally *Advising Clients to Apologize*, *supra* note 1; *Legislating Apology*, *supra* note 1; see also Levi, *supra* note 92, at 1171 ("For instance, critics might ask, if a plaintiff settles because she's emotionally fulfilled by an apology, isn't she being duped out of her legal entitlement—an entitlement that the apology itself makes concrete?"); O'Hara & Yarn, *supra* note 1, at 1186 ("[A]pology can be used as a tool for organizations to strategically take advantage of individual victims' instincts to forgive in the face of apology."). There is also some empirical evidence that an apology "script" dictates that forgiveness by the recipient will follow an apology by an offender. See Mark Bennett & Christopher Dewberry, "I've Said I'm Sorry, Haven't I?" *A Study of the Identity Implications and Constraints that Apologies Create for Their Recipients*, 13 CURRENT PSYCHOL. 10 (1994).

95. O'Hara *supra* note 7, at 1076-77 (noting that, "[w]hile the subordinate uses apology to reestablish the dominant's favor, the dominant uses apology in lieu of other compensation.").

96. See *supra* Part I.

concern about how jurors will react to a case in which a provider has disclosed error and apologized. While some initial steps have been taken in exploring the influences of apologies on the behavior of claimants, few steps have been taken toward understanding the effects of disclosure and apologies on jury decision making.⁹⁷

CONCLUSION

The increased attention to the role of apologies in the resolution of health care disputes is a positive step in the development of new approaches for dispute resolution in this area. Given the nature of the physician-patient relationship and the nature of disputes that result when there is an adverse medical outcome, consideration of the role of apologies in this area of law seems particularly appropriate. There is an emerging body of empirical research that uses a variety of methodologies to examine a range of questions related to disclosure and apology. This research suggests that apologies have the potential to facilitate the settlement of health care disputes. The effects of apologies, however, are likely to be complex and dependent on a variety of factors including the nature of the apology, the situation, and the parties involved. Thus, continuing to examine the potential role of apologies in resolving health care disputes will likely yield benefits that will redound to health care providers and patients alike.

97. *But see* Brian H. Bornstein et al., *The Effects of Defendant Remorse on Mock Juror Decisions in a Malpractice Case*, 20 BEHAV. SCI. & L. 393 (2002).